Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

RENAISSANCE HOSPITAL
C/O BURTON & HYDE PLLC
PO BOX 684749
AUSTIN TX 78768-4749

Respondent Name

ZURICH AMERICAN INSURANCE CO

Carrier's Austin Representative Box

Box Number 19

MFDR Tracking Number

M4-06-4722-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "…the fair and reasonable reimbursement amount for this hospital outpatient admission should be commensurate with the average amount paid by all insurance carriers in the Texas workers' compensation system in the same year as this admission for those admissions involving the same Principal Diagnosis Code and Principal Procedure Code."

Amount in Dispute: $6,165.62

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Requestor fails to prove its entitled to additional reimbursement under the statutory standards. Requestor has provided no testimony from anyone who has medical, accounting, statistical or other special expertise, and offered no expert opinions. The sum total of Requestor's 'evidence' is its own attorneys' simple assertion the proffered method satisfies some of the requirements."

Response Submitted by: Flahive, Ogden & Latson, P O Box 201329, Austin, TX 78720

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 1, 2005	Outpatient Services	$6,165.62	$610.13

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes
2. 28 Texas Administrative Code §134.1, effective May 16, 2002, 27 *Texas Register* 4047, requires that

"Reimbursement for services not identified in an established fee guideline shall be reimbursed at fair and reasonable rates as described in the Texas Workers' Compensation Act, §413.011 until such period that specific fee guidelines are established by the commission."

3. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
4. This request for medical fee dispute resolution was received by the Division on March 9, 2006. Pursuant to 28 Texas Administrative Code §133.307(g)(3), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, the Division notified the requestor on March 28, 2006 to send additional documentation relevant to the fee dispute as set forth in the rule.
5. U.S. Bankruptcy Judge Michael Lynn issued a "STIPULATION AND ORDER GRANTING RELIEF FROM AUTOMATIC STAY TO PERMIT CONTINUANCE AND ADJUDICATION OF DISPUTED WORKERS COMPENSATION CLAIMS BEFORE THE TEXAS STATE OFFICE OF ADMINISTRATIVE HEARINGS," dated August 27, 2010, in the case of *In re: Renaissance Hospital – Grand Prairie, Inc. d/b/a/ Renaissance Hospital – Grand Prairie, et al.*, in the United States Bankruptcy Court for the Northern District of Texas, Fort Worth Division in Case No. 08-43775-7. The order lifted the automatic stay to allow continuance of the Claim Adjudication Process as to the Workers' Compensation Receivables before SOAH, effective October 1, 2010. The order specified John Dee Spicer as the Chapter 7 Trustee of the debtor's estate. By letter dated October 5, 2010, Mr. Spicer provided express written authorization for Cass Burton of the law office of Burton & Hyde, PLLC, PO Box 684749, Austin, Texas 78768-4749, to be the point of contact on Mr. Spicer's behalf relating to matters between and among the debtors and the Division concerning medical fee disputes. The Division will utilize this address in all communications with the requestor regarding this medical fee dispute.
6. By letter dated August 3, 2011, the attorney for the requestor provided *REQUESTOR'S AMENDED POSITION STATEMENT (RENAISSANCE HOSPITAL – GROVES)* that specified, in pertinent part, an "Additional Reimbursement Amount Owed" of $610.13. The Division notes that the amount in dispute of $6,165.62 specified above is the original amount in dispute as indicated in the requestor's *TABLE OF DISPUTED SERVICES* submitted prior to the *REQUESTOR'S AMENDED POSITION STATEMENT*.
7. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - W10 (850-054)- No denial code description give.

Findings

1. The respondent's supplemental response asserts that "Requestor's attempt to raise an entirely new rationale and new claim for a 'fair and reasonable' allowance for outpatient services must be denied." In support of this assertion, the respondent states "The time for staking out a position is during the informal initial bill submission and reconsideration process." No documentation was found to support the respondent's assertion that the requestor is limited to arguing at Medical Fee Dispute Resolution only those positions presented to the carrier during the bill submission and reconsideration process. The Division notes that while 28 Texas Administrative Code §133.307(j)(2), 27 *Texas Register* 12282, prohibits the respondent from raising new denial reasons or defenses that were not presented to the requestor prior to the filing of the request for dispute resolution, no similar bar is set against the requestor. The respondent further asserts that "This unsolicited document does not qualify as a supplemental statement under Division rules… upon filing of its request for dispute resolution, Requestor was then required to provide a position statement which included Requestor's reasoning as to why its disputed fee should be paid in the amount claimed, how the Labor Code, Division rules and fee guidelines impact their claim and how the submitted documentation supported their position. Requestor did these things but not for these newly created positions… Certainly, any requestor or respondent should be able to timely provide any supplemental responses and evidence to support its stated position. But, there is no rule which allows such a belated and complete change of position… Requestor's entirely new claim found within its recent 'Amended' statement of position… is tardy by years and should not be considered." No documentation was found to support the respondent's assertion that the submitted information was untimely. While Division rules set timely filing limits for the initial request and response, there is no time limitation as to the submission of supplemental information. The Division notes that the medical fee dispute process has allowed, for many years, both parties to a dispute to submit additional information until the assigned medical dispute resolution officer begins adjudication of the dispute. The Division has previously stated in the adoption preamble to 28 Texas Administrative Code §133.307, 31 *Texas Register* 10314, that "The Division must be able to obtain relevant and necessary information in order to determine fundamental issues regarding fee disputes." The supplemental filings in the present dispute are directly related to the "fair and reasonable" fee reimbursement methodology at issue. Moreover, the requestor noted in its amended position statement that "it is necessary and proper to update the file because the Requestor

has a new attorney of record after the health care provider was placed in bankruptcy." The respondent has had notice and opportunity to respond to all of the requestor's filings in this dispute, and has availed itself of the opportunity to do so. Therefore the submitted information will be considered in this review.

2. 28 Texas Administrative Code §133.307(g)(3)(D), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement." Review of the submitted documentation finds that:
   - The requestor's amended position statement asserts that "…the fair and reasonable reimbursement amount for this hospital outpatient admission should be commensurate with the average amount paid by all insurance carriers in the Texas workers' compensation system in the same year as this admission for those admissions involving the same Principal Diagnosis Code and Principal Procedure Code."
   - In support of the requested reimbursement methodology the requestor states that "Ordering additional reimbursement based on the average amount paid system-wide in Texas achieves effective medical cost control because it prevents overpayment... creates an expectation of fair reimbursement; and… encourages health care providers to continue to offer quality medical care to injured employees… Ordering additional reimbursement for at least the average amount paid for a hospital outpatient admission during the same year of service and involving the same Principal Diagnosis Code and Principal Procedure Code ensures that similar procedures provided in similar circumstances receive similar reimbursement… The average amount paid for similar admissions as put forward by the Requestor is based on a study of data maintained by the Division."
   - The Division notes that it has utilized similar data to determine "fair and reasonable" fee guidelines. See, for example, the adoption preamble to the *Hospital Facility Fee Guideline—Outpatient* at 28 Texas Administrative Code §134.403, 33 *Texas Register* 400-407, which specified, in pertinent parts, that "In maintaining a medical billing database, the Division requires carriers to submit billing and reimbursement information to the Division on a regular basis… The Division provided Milliman with the 837 data set for CY 2005, which included information on approximately 12,000 inpatient billing lines and 166,000 hospital outpatient billing lines… Milliman estimated that CY 2005 Texas workers' compensation outpatient facility reimbursement represented approximately 186 percent of Medicare allowable levels for outpatient services… The Division considered the issues of medical cost containment as prescribed by Labor Code §413.011… Research conducted by the Workers' Compensation Research Institute concludes that... hospital outpatient payments per claim in Texas were lower than the 13-state median studied… Based on all of these factors… The Division adopts PAFs of 200 percent and 130 percent of Medicare reimbursement for use in determining Texas workers' compensation outpatient facility service reimbursement."
   - The requestor submitted documentation to support the state-wide, annual, average reimbursement in Texas for the principal diagnosis code and principal procedure code of the disputed services during the year that the services were rendered.
   - The requestor has explained and supported that the requested reimbursement methodology would satisfy the requirements of 28 Texas Administrative Code §134.1.

   The request for additional reimbursement is supported. Thorough review of the submitted documentation finds that the requestor has discussed, demonstrated, and justified that the average amount paid by all insurance carriers in the Texas workers' compensation system in the same year as the disputed admission for those admissions involving the same principal diagnosis code and principal procedure code is a fair and reasonable rate of reimbursement for the services in dispute.
3. 28 Texas Administrative Code §133.307(i), effective January 1, 2003, 27 *Texas Register* 12282, states that "A respondent who fails to timely file a response waives the right to respond. The commission shall deem a response to be filed on the date the division receives a response. If the respondent does not respond timely, the commission shall issue a decision based on the request. The response will be considered timely if received by the commission within 14 days after the date the respondent received the copy of the requestor's additional documentation." Review of the submitted documentation finds that a response was not received by the commission within 14 days after the date the respondent received the copy of the requestor's additional documentation. The Division concludes that the respondent has failed to meet the requirements of §133.307(i) and has waived the right to respond. The Division will therefore issue a decision based on the request.
4. 28 Texas Administrative Code §133.307(j)(1)(A), effective January 1, 2003, 27 *Texas Register* 12282, requires that each response, unless previously provided in the request and requestor's additional documentation, shall include "documentation of carrier response to reconsideration in accordance with commission rules." Review of the submitted documentation finds that the respondent has not provided documentation of carrier response to reconsideration in accordance with commission rules. The Division concludes that the respondent has not met the requirements of §133.307(j)(1)(A).
5. 28 Texas Administrative Code §133.307(j)(1)(C), effective January 1, 2003, 27 *Texas Register* 12282,

requires that each response, unless previously provided in the request and requestor's additional documentation, shall include "a copy of all medical audit summaries and/or explanations of benefits (EOBs) relevant to the fee dispute, or a statement certifying that the carrier did not receive the provider's disputed billing prior to the request." Review of the submitted documentation finds that the respondent has not provided a copy of all medical audit summaries and/or explanations of benefits (EOBs) relevant to the fee dispute, or a statement certifying that the carrier did not receive the provider's disputed billing prior to the request. The Division concludes that the respondent has not met the requirements of §133.307(j)(1)(C).

6. 28 Texas Administrative Code §133.307(j)(1)(E)(i), effective January 1, 2003, 27 *Texas Register* 12282, requires that each response shall include a statement of the disputed fee issue(s), which includes "a description of the health care in dispute." Review of the submitted documentation finds that the respondent has not provided a description of the health care in dispute. The Division concludes that the respondent has not met the requirements of §133.307(j)(1)(E)(i).
7. 28 Texas Administrative Code §133.307(j)(1)(E)(ii), effective January 1, 2003, 27 *Texas Register* 12282, requires that each response shall include a statement of the disputed fee issue(s), which includes "a statement of the reasons that the disputed medical fees should not be paid..." Review of the submitted documentation finds that the respondent has not provided a statement of the reasons that the disputed medical fees should not be paid. The Division concludes that the respondent has not met the requirements of §133.307(j)(1)(E)(ii).
8. 28 Texas Administrative Code §133.307(j)(1)(E)(iii), effective January 1, 2003, 27 *Texas Register* 12282, requires that each response shall include a statement of the disputed fee issue(s), which includes "a discussion of how the Texas Labor Code and commission rules, including fee guidelines, impact the disputed fee issues." Review of the submitted documentation finds that the respondent has not discussed how the Texas Labor Code and commission rules, including fee guidelines, impact the disputed fee issues. The Division concludes that the respondent has not met the requirements of §133.307(j)(1)(E)(iii).
9. 28 Texas Administrative Code §133.307(j)(1)(E)(iv), effective January 1, 2003, 27 *Texas Register* 12282, requires that each response shall include a statement of the disputed fee issue(s), which includes "a discussion regarding how the submitted documentation supports the respondent position for each disputed fee issue." Review of the submitted documentation finds that the respondent has not discussed how the submitted documentation supports the respondent position for each disputed fee issue. The Division concludes that the respondent has not met the requirements of §133.307(j)(1)(E)(iv).
10. The respondent's supplemental response asserts that "A carrier/self-insured has no burden of proof in this proceeding." However, 28 Texas Administrative Code §133.307(j)(1)(F), effective January 1, 2003, 27 *Texas Register* 12282, requires that each response shall include "if the dispute involves health care for which the commission has not established a maximum allowable reimbursement, documentation that discusses, demonstrates, and justifies that the amount the respondent paid is a fair and reasonable rate of reimbursement in accordance with Texas Labor Code §413.011 and §§133.1 and 134.1 of this title." In the present dispute, the requestor has discussed, demonstrated and justified that the amount being sought is a fair and reasonable rate. This dispute involves health care for which the Division has not established a maximum allowable reimbursement; therefore, per §133.307(j)(1)(F) the respondent is similarly required to discuss, demonstrate and justify that the amount paid is a fair and reasonable rate of reimbursement for the services in dispute.
11. 28 Texas Administrative Code §133.307(j)(1)(F), effective January 1, 2003, 27 *Texas Register* 12282, requires that each response shall include "if the dispute involves health care for which the commission has not established a maximum allowable reimbursement, documentation that discusses, demonstrates, and justifies that the amount the respondent paid is a fair and reasonable rate of reimbursement in accordance with Texas Labor Code §413.011 and §§133.1 and 134.1 of this title." Review of the submitted documentation finds that:
    - The respondent has not articulated a methodology under which fair and reasonable reimbursement should be calculated.
    - The respondent's position statement asserts that "Requestor fails to prove its entitled to additional reimbursement under the statutory standards. Requestor has provided no testimony from anyone who has medical, accounting, statistical or other special expertise, and offered no expert opinions. The sum total of Requestor's 'evidence' is its own attorneys' simple assertion the proffered method satisfies some of the requirements."
    - The respondent did not discuss or explain how the amount paid represents a fair and reasonable reimbursement for the services in dispute.
    - The respondent did not submit documentation to support that the amount paid is a fair and reasonable rate of reimbursement for the disputed services.
    - The respondent did not submit nationally recognized published studies, published Division medical dispute decisions, or documentation of values assigned for services involving similar work and resource

commitments to support that the amount paid is a fair and reasonable reimbursement for the services in dispute.

- The respondent did not explain how the amount paid satisfies the requirements of 28 Texas Administrative Code §134.1.

The respondent's position is not supported. Thorough review of the submitted documentation finds that the respondent has not demonstrated or justified that the amount paid is a fair and reasonable rate of reimbursement for the services in dispute. The Division concludes that the respondent has not met the requirements of 28 Texas Administrative Code §133.307(j)(1)(F).

12. The Division finds that the documentation submitted in support of the fair and reasonable methodology proposed by the requestor based on the average amount paid by all insurance carriers in the same year for admissions involving the same principal diagnosis code and principal procedure code as the services in dispute is the best evidence in this dispute of an amount that will achieve a fair and reasonable reimbursement for the services in this dispute. Reimbursement will therefore be calculated as follows. Review of the medical bill finds that the principal diagnosis code for the disputed services is 722.1. The principal procedure code is 03.92. The requestor submitted documentation to support that the average, state-wide reimbursement for this diagnosis code and procedure code performed in 2005 was $1,510.13. This amount less the amount previously paid by the respondent of $900.00 leaves an amount due to the requestor of $610.13. This amount is recommended.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the requestor has established that additional reimbursement is due. The Division concludes that the carrier's response was not submitted in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307. The Division further concludes that the respondent failed to support that the amount paid by the insurance carrier is a fair and reasonable reimbursement in accordance with Division rule at 28 Texas Administrative Code §134.1. As a result, the amount ordered is $610.13.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $610.13 plus applicable accrued interest per 28 Texas Administrative Code §134.803, and/or §134.130 if applicable, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	03/06/2012 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.